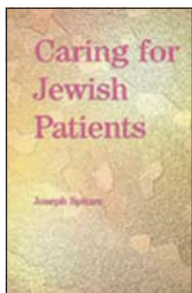


reviews

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Caring for Jewish Patients

Joseph Spitzer



Radcliffe Medical Press,
£24.95, pp 232
ISBN 1 85775 991 5

Rating: ★★★

A patient looks down and makes poor eye contact. Could he be embarrassed, worried, or depressed? *Caring for Jewish Patients* offers an alternative explanation: orthodox Jewish patients may avoid eye contact with a doctor of the opposite sex.

Author Joseph Spitzer is an orthodox Jew. He is also a general practitioner in Stamford Hill, north London, home to Europe's largest

orthodox Jewish community. Spitzer writes eloquently about his community and with an admirable objectivity. Perhaps it is this mixture of insider insights coupled with the sort of neutrality you might expect from an outsider that makes this book so absorbing and thought provoking.

The Jewish community is more diverse than one might suppose, and alongside the different strands there are levels of religious observance that make generalising impossible. Spitzer's mission is clear: he wants to provide the non-Jewish doctor or nurse with information about his faith to help them understand, engage with, and treat Jewish patients. He does this with remarkable clarity. Readers are taken through a fascinating account of different festivals, rituals, and rites of passage.

Spitzer's text will spare doctors many potential blunders. Most non-Jews are aware of certain Jewish food laws, but most doctors probably don't realise oral medications must also be kosher. For example, Calpol contains glycerine and is therefore non-kosher. Medinol contains glycerine known to be of

vegetable origin and is therefore kosher. In contrast with current medical practice, Jewish orthodoxy discourages doctors from telling patients that they are terminally ill. Hope, it is argued, should not be snuffed out prematurely, as this could cause unnecessary suffering.

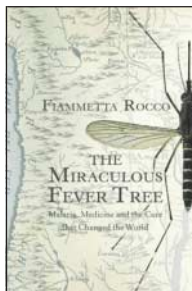
The text is broken up with case vignettes. Sharon, a Jewish medical graduate, approaches the postgraduate dean and explains that she will not be able to do pre-registration house jobs that involve Friday or Saturday nights on call. Fortunately for Sharon, a job share partner—presumably a non-orthodox Jew—is found.

This book draws attention to connections between religion and health, faith and illness. Those reading it will learn about the impact of different elements of Jewish life and culture on wellbeing, disease, diagnosis, and recovery, and therefore be better placed to treat Jewish patients successfully.

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The Miraculous Fever Tree: Malaria, Medicine and the Cure that Changed the World

Fiammetta Rocco



Harper Collins, £16.99,
pp 352
ISBN 0 00257202 8

Rating: ★★★★★

Legend has it that the cure for malaria was discovered in the 17th century by the countess of Cinchona, wife of the viceroy of Peru, when she was revived from a life threatening fever by a dose of bitter Peruvian bark. Learning of her miraculous recovery the people of Lima begged the countess

to help them, for they regularly succumbed to the same fever. She ordered that a large quantity of the remedy be distributed among the poor, which was subsequently named "the countess's powder"—the same powder which her husband brought back to Europe upon his return voyage.

The cure was quinine, but the legend is exactly that, a legend. Nobody can be sure who first discovered the miracle of the *Cinchona calisaya* tree and its bark, for the tree grows high in the Andes where malaria is unknown. But the arrival of quinine on the shores of Europe was not the legacy of the countess or her husband; instead, it was a gift from an hitherto unknown Jesuit priest, Agustino Salumbrino, in 1631.

Eight years earlier, in the summer of 1623, Pope Gregory XV had died. As the cardinals and their attendants gathered to elect his successor, many fell victim to the "mal aria" or "bad air" of Rome. To contain the problem, the newly appointed Pope Urban VIII decreed that a cure should be found for the fever that had afflicted so many. And so Brother Salumbrino came to dispatch his powdered bark from Peru.

Despite its effectiveness, Protestants dismissed "the Jesuit's bark," believing it to

be some form of "papal poison," and chose to continue treating "agues"—the English term for "mal aria"—with enemas and blood-letting. This ignorance was not confined to England; in Rome they continued to believe that the disease was spread by breathing, while the French argued that spiders were the cause.

Having unearthed fresh documents in Peru, Fiammetta Rocco has re-examined research from the Vatican and the Indian Archives in Seville to provide a novel approach to the subject of malaria. Numerous colourful anecdotes, such as those described here, bring alive the historical aspects of malaria. Rocco's own experiences of the disease—she, her father, and her grandfather have all survived it—add an important personal perspective.

Rocco is also well aware of the deadly nature of malaria, and the fact that somebody dies from it every 15 seconds adds a sense of urgency to the story. Despite this, Rocco ends on a positive note; citing her recent visit to the Congo where 500 tonnes of generic antimalarials (at a cost of £1 a course) are produced annually.

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Items reviewed are rated on a 4 star scale
(4=excellent)

PERSONAL VIEWS

The first world's role in the third world brain drain

We in the third world are rarely willing to admit to our "third worldliness." We aspire to first world standards, and the things we want more than anything else are hotels of international standard, a well reputed university, and, in particular, good medical and nursing schools. We are greatly gratified by the recognition of our graduates as being of international standard—"Our doctors and nurses are as good as any others"—but there are difficulties with this. As soon as a country produces graduates of an acceptable international standard then it is "fishing in the same pond" as first world countries for their services. It is inevitable that doctors and nurses will be attracted to countries where salaries or working conditions are seen as better.

The situation becomes aggravated when conditions at home deteriorate. Then even the most loyal professionals feel their attachment stretched to breaking point by the need to help their families and the natural desire to advance themselves. So it is that the hour of departure comes nearer and the country loses another skilled person. This is happening all over the third world. No one is to blame, and probably nothing can be done about it, but a variety of factors need to be considered.

Firstly, in our anxiety to be part of and recognised as first world we in the third world have produced professionals whose expectations we cannot meet, because out-



BETTY PRESS/PANOS PICTURES

Where will they go?

side a few centres we do not have the financial resources to compete. Was that sensible? Secondly, the first world has produced a compounding factor. It has allowed successive governments, in their meanness and penny pinching, to so underfund the health services that few of its own young people want to go into nursing and the ancillary fields. Consequently many of its hospitals are desperate for staff and will recruit from anywhere they can. Salaries may seem inadequate locally, but to us in the third world they represent a glittering fortune, and no one can blame qualified people for going after them.

Is there a solution to this problem? Probably not—at least not in the short term.

The northern hemisphere will continue to suck in qualified people from the third world

In the past we have modelled our teaching programmes and our output on the so called developed world because that seemed the right thing to do. Has this been a mistake? I remember saying many years ago, when a new medical school was about to be opened in another country, that it would be better for that country to produce graduates whose qualifications are not recognised

abroad, then although they might be functioning at a lower standard than elsewhere at least they would be there and of some help to that country. Naturally this was greeted by stony silence, but it's the truth. It's a very difficult matter, because the third world does not have the money to pay well enough to hold the trained people and yet does not want to be seen to be producing a substandard (by first world estimations, at least) product. It is clear that there is no immediate answer. The first world is likely to go on underpaying staff, so that the professions will be unfilled, and we in the third world will be too proud to stop training top class people. Furthermore, while the home situation remains unattractive, compared with elsewhere, the void that is the northern hemisphere will continue to suck in qualified people from the third world in increasing numbers, and we will continue to finance it. At least the first world might consider setting our very considerable contribution to its health services against the third world's debts, otherwise it becomes just another form of colonialism. We produce the resource; the first world takes it. I admit that there is one benefit to us: a lot of money is sent home to support families. But that is a poor substitute for the absent skilled person.

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WEBSITE
OF THE
WEEK

Intelligence A paper in this week's *BMJ* suggests that A-level results (which test achievement), rather than intelligence testing, predict future success in medical careers (p 139). But how much do we really understand about what intelligence is and what it means for us today?

The internet provides a vast array of speculation on the subject, but most of us will be more than just a little curious to know how we measure up. Go to Mensa to do the test (www.mensa.org.uk/mentajoining.html) and then compare your IQ to some famous names in history, from Darwin to Descartes (<http://home8.swipnet.se/~w-80790/index.htm>).

For a short introduction to intelligence, the BBC is a good start (www.bbc.co.uk/science/hotspots/intelligence/index.shtml#definition). <http://psychology.about.com/library/weekly/aa071001a.htm> provides short 'expert summaries', and the journal *Intelligence* contains up to date research in the field (www.elsevier.com/locate/issn/01602896).

Artificial Intelligence (AI) has become a bit of a buzz word of late. The MIT Artificial Intelligence Laboratory's website has interesting research abstracts on the application of AI to medical robotics, in particular motor control and movement disorders (www.ai.mit.edu/research/abstracts/abstracts2002/medical-robotics/medical-robotics.shtml).

Few can have missed the furor created by Herrnstein and Murray's book *The Bell Curve: Intelligence and Class Structure in American Life*. Some follow up can be found in Earl Hunt's discussion of the role of intelligence in modern society (www.americanscientist.org/template/AssetDetail/assetid/24538?fulltext=true) and in Robert Sternberg's interview in *Skeptic* magazine about the Bell Curve (www.skeptic.com/03.3.fm-sternberg-interview.html).

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Are HIV positive asylum seekers an unfair burden on the NHS?

The extra burden on the NHS is one of the issues cited in the controversy over the number of asylum seekers entering the United Kingdom. My specialty, which includes care of patients infected with HIV, has seen a considerable increase in the number of new diagnoses of HIV in patients who acquired the virus abroad, such that most new cases in the United Kingdom are now in this category. A major proportion of these patients are asylum seekers, largely from sub-Saharan Africa.

Doctors treating asylum seekers are often required to support applications for exceptional leave to remain in this country, on the grounds that antiretroviral treatment is not widely available (or affordable) in their countries of origin. The growing realisation among doctors and politicians that a sizeable and increasing amount of resources is being taken up in the care of these patients has led to two opposing points of view. The first view is that most of these unfortunate people are fleeing persecution and deserve our full support and care, regardless of the cost to the country. Some holders of this view go further, reasoning that because most of the asylum seekers who reach Britain are resourceful by nature they provide a welcome influx of motivated immigrants. The second view is that most of the HIV positive asylum seekers are either "health tourists" (coming here for treatment they couldn't afford at home) or economic migrants abusing our system, and we shouldn't be using scarce resources on them.

I suspect that although most healthcare professionals who come into contact with this group of patients would admit that both sides of the argument have some truth they largely sympathise with the first point of view. This is probably because, on an individual basis, we see enough evidence of torture and suffering among these people to make the prospect of sending them all home to die of AIDS, if not further persecution, inhumane in the extreme. Naturally, this view overshadows the uncomfortable

suspicion that many of the patients we see probably are health tourists or economic migrants.

The first position, however, has several difficulties. It neglects the reality that the cost of caring for these patients is not insubstantial—each additional patient being treated with antiretroviral drugs means two or three fewer hip replacements each year. It also assumes that adequate treatment of HIV infection can be given only in this country. This is probably untrue,

as there is growing evidence that patients who are given triple antiretroviral treatment in the developing world, without the sophisticated monitoring we use here, on the whole fare as

well as they would in this country. Furthermore, there is the counter-argument that the resourceful people who make it to Britain to claim asylum are more useful to the poor African countries they have come from.

Clearly there is a considerable way to go before universal care of all HIV positive patients in the developing world is achieved. Substantially more funding needs to go into increasing access to cheaper antiretroviral drugs, training of HIV specialists, and other support services—all of which will require concerted efforts by governments around the world. The main benefit of such a strategy will be that HIV positive people in poor countries will not face the stark choice of remaining there and dying of AIDS or getting on a plane to Europe. The resources currently used for health care, social security, and asylum applications for those immigrants who have not been persecuted could instead be spent on HIV positive people in the developing countries, where the same amount of money would save many more lives.

Until such universal care is available, HIV specialists have no realistic option—practically or ethically—but to give HIV positive asylum seekers the care they need and to support their applications to remain in Britain. But we should not forget the 30 million or so other people living with HIV in the developing world, most of whom have little immediate hope of being spared from their affliction.

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The cost of caring for these patients is not insubstantial

HIV specialists have no option but to give asylum seekers the care they need

SOUNDINGS

Bullshitting

I remember that we were sitting in a room analysing videoed consultations. The registrar on the video sat the patient down. "You have sacroiliitis," she said.

We all finished watching the video, consultation technique was discussed, and then someone pointed out that the registrar couldn't possibly say that the diagnosis was sacroiliitis. All that one could say on the information presented was that the patient had mechanical low back pain.

"Oh, well," someone else said, "We all do that." I assumed by this that they meant that we all made up diagnoses of spurious diagnostic accuracy to keep the patient happy.

There was a pause, and then a colleague said in a slightly embarrassed tone: "Well, I don't do that." There was an awkward silence and then we moved on to discuss the knotty question of whether the registrar had *empathised* with the patient.

This episode occurred several years ago but it has stayed with me. I suspect that I was probably guilty of the same sin—of dressing up diagnostic uncertainty with an impressive, but spurious, diagnostic accuracy. I have avoided doing it ever since.

There is quite a lot published about why patients trust some doctors and not others. The reasons for trust, or the lack of it, are undoubtedly multiple. As junior doctors we assume that the patient will distrust us if we seem uncertain, and that may be true.

The risk is that the bullshitting learnt as a junior may persist. And the odd thing is that it is tolerated. "We all do it." But I suspect that most human beings are rather finely attuned to picking up the minor levels of deceit in such a practice, which may explain part of the spectrum between trust and distrust that patients feel.

I recently had to fill out a form for appraisal, which asked me about my "probity." I remembered the story of Evelyn Waugh visiting the United States. The entry form asked him if any part of the purpose of his visit was to "subjugate the government of the United States." He wrote, "sole purpose of visit," and was detained for a week. Maybe my appraisal form should, more profitably, have asked me if I bullshitted to patients. It would at least have caused me to examine my conscience.

Now, instead of saying to patients that they have sacroiliitis, I tell them that they are allergic to candida.

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